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Payments to Informal vs. Formal Home Care Providers: Policy Divergence Affects the Elderly and Their Families in Michigan and Illinois

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Abstract

States' policies vary widely on paying friends and family rather than home care agencies to care for the elderly. This analysis explores two state programs that exemplify different payment options: Michigan, which pays clients' informal caregivers, and Illinois which generally pays agencies to provide services. It asks how different payment policies affect clients, specifically exploring program structure (division of labor and bases for need determination) and financing incentives created by Medicaid (centralization, means testing and quality assurance). These factors shape provider and client preferences, well being and assessment of care quality.

Comparatively, Illinois' approach favors professionalism, high cost/quality, documentation, and an orientation toward medical and physical need. It has experienced high worker turnover and less regard for caregiver-client relationships. Michigan's approach favors informality, casual accountability, long term stability of helping relationships, and respect for client preferences and autonomy. Both approaches offer important client benefits, but state precedents and incentives to administering agencies have shaped their overall direction. The recent rapid growth of the home care industry in Illinois could proscribe a fuller range of provider options. The authors recommend greater flexibility in considering states' payment.

States' Differing Approaches to Home Based Care

Medicaid coverage of home care services has grown dramatically since 1982, when waivers for Home and Community Based Care (under Section 2176) first permitted states to use federal matching funds to divert care from institutions.[1] States' choices to contract with formal agencies, as opposed to informal care providers, particularly family members and friends, present an interesting basis upon which to comparatively analyze their Medicaid home care services.

A number of recent studies have explored states' programs to pay informal caregivers, generally friends and relatives. Burwell examined 13 such state programs, and found variance in terms of size, funding source, and relationship to other programs.[2] Linsk and associates found key differences in provisions for payments to family members, including: outright prohibitions against relatives receiving payment, provision of a "family or attendant allowance," and reliance on home care agency employees with de facto exclusion of informal caregivers (family or friends) from employment or eligibility for reimbursement.[3] Despite the prevalence of agency provided care in the U.S., 32 of the 45 states responding reported having at least <u>some</u> provision for paying family members to care for an elderly dependent member.

Biegel and associates identified 23 states providing significant economic incentives (both tax incentives and direct payment programs) to family caregivers. Observing great variation in eligibility requirements, level of benefits and payments, as well as program administration and structure, he notes that "direct payment programs tend to be targeted at the lower income, higher risk elderly to a greater degree than tax benefit programs."[4] A related analysis by

Osterbusch and associates frames reimbursement of family care, which is largely provided by women, as an issue of gender justice[5]. These studies lack in-depth analysis of individual state programs and thus reveal little about how different payment policies affect older clients. The present study does this in examining only two quite similar states which take contrasting approaches to informal care.

Programs in Michigan and Illinois are ideal for in depth analysis. Both are large, industrial states somewhat similar in size, ethnic composition, and extent of urbanization. The key programs providing home care to the elderly in Michigan are based upon payment of informal caregivers, while in Illinois this option is only occasionally exercised.

The Illinois Community Care Program operated by the state aging agency, the Department on Aging (IDOA), represents a prototypic "agency based model" reliant upon agencies to determine eligibility and provide direct services. The Michigan Adult Home Help program, operated by the state welfare agency, the Department of Social Services (DSS), represents a prototypic "client based model" in that it relies upon the client to suggest appropriate caregivers who then provide the direct service. Each is described below.

Michigan's Home Help program relies heavily on family and friends as the paid providers of choice and closely resembles a family, or attendant, allowance model such as that of the Veterans Administration. The program provides a cash transfer to the client who pays the caregiver of his or her own choice, who may be a relative. Illinois contracts community care services to outside agencies and neither prohibits nor encourages these agencies regarding the hiring of

relatives. The contract agencies are permitted to make their own policies. This almost always results in some de facto exclusion of informal providers because of agencies' preference for full-time flexible employees.

Both states provide homemaker and chore or housekeeping services, while Michigan also provides personal care service. Both programs pay for similar assistance with activities of daily living in order to deter or preclude nursing home placement. The main difference is in who receives payment, and who selects and pays the caregiver.

Two dimensions of state policy choice appear to create the incentives that have resulted in program divergence: the states' program structure and means of financing.[6] Program structure includes Illinois' reliance on formal contract agencies to provide services to clients, while Michigan relies upon state employees to contract with informal caregivers. Financing includes each state's use of Medicaid and the incentives created by the Home and Community Based Care waivers. This study contrasts how the incentives created by structure and financing appear to differentially affect providers' and clients' preferences, well being, and assessment of care quality.

Methods

Interviews were conducted with key state officials, case managers, and contract agency staff from both states to explore the procedures and values operating in each state's program. Program performance, financing, and expenditure data were gathered from published agency reports. A survey of Illinois home care agencies was reviewed[7] and exploratory interviews were conducted with a small number of clients and

their caregivers in Michigan. The program data were analyzed to delineate the structure and financing of each state program and the key effects felt by clients. The interview and survey findings provide salient statements that highlight respondents' policy perspectives.

Findings

The main features found in each state's basic home care program are summarized in Table I. The salient contrasting elements include how

TABLE I ABOUT HERE

the program developed, the structure of service delivery, the mechanisms for financing, and the impacts upon clients.

Program Origins and Context

Long term care services in Michigan have been characterized by a gradual and steady growth of home care services over a long period, while Illinois experienced more recent and rapid growth. In the past decade Michigan has constrained nursing home construction and utilization by Medicaid recipients, while it gradually developed a broad array of supervised living arrangements (alternatives to nursing homes). In 1976 Michigan had 47.7 nursing home beds per 1,000 elderly, while Illinois had 50.0,[8] only very slightly more, but by 1981 the Michigan rate was 49.3, while in Illinois it was 68.3.[9] Michigan imposed tight controls on nursing homes construction through Certificate of Need. Nursing home utilization by Medicaid patients declined from 32,000 in 1975 to 29,000 in 1985. Michigan also made extensive use of board and care homes and adult foster care homes, expanding adult foster care beds from 13,000 to 18,500 in this period.

The most substantial growth, however, occurred in the two home-based care programs of the Department of Social Services, Adult Home Help and Medicaid Home Health. Home Help provides personal care and chore housekeeping services, while Home Health, in the Medicaid budget, provides nursing care services.

Between 1975 and 1985, Home Help grew from 9,800 to 22,700 clients, and Home Health grew from 2,810 to 7,925 clients. Clients over age 60 comprise a growing share of Home Help (currently 72% of the program's 22,700 users, up from 67.2% of the users just four years before).[10] About half of the 7,925 Home Health users are over age 60. Deinstitutionalization of the mentally ill, which also occurred during this period, was facilitated by a shift of Department of Mental Health funding and responsibility to local mental health centers.

In Michigan the private home health care industry is less developed than in Illinois, at least partly because, in providing directly for the dependent population through the Home Help program and adult foster care, Michigan has created few market incentives for private nursing home corporations or home health agencies to expand or move into the state. Total institutional beds (nursing homes and state institutions) increased by only 10.2% from 1975 to 1985 (from 44,000 to 48,513),[11] while the elderly population grew by 22%. Over time state alternatives to nursing homes have facilitated a significant diversion of the growing poor elderly population from more expensive nursing home settings, while reimbursement for alternatives is received generally by individual informal caregivers and small homes.

Illinois' commitment to community based long term care was more recent and dramatic. With the closure of three state psychiatric

institutions in 1982, large numbers of disabled clients were transferred to community nursing homes, reducing access to nursing homes for other Medicaid patients, and necessitating development of less expensive alternatives for the poor elderly in the community. Adult foster care, which cannot be developed quickly, remains underdeveloped.

To absorb this pressure, Illinois dramatically expanded its home care service in the early 1980s. Community Care Program utilization expanded from 14,200 clients served in FY84 to 22,085 served in FY86. The home care industry responded to this stimulus with hundreds of home care agencies bidding for contracts to implement state-funded community services. The state delivery system's turn to contract agencies was followed by very rapid growth of the home care industry.

Structure of Service Delivery and Payment System

Dispersion of Care Planning

The Illinois Community Care Program contracts with local agencies to serve as Case Coordination Units (CCU) for a given region for a given period. The CCU assesses the client, authorizes hours of care and payment, and monitors the provision of care. The CCU also acts as a nursing home preadmission screening authority.

In Michigan, staff in the DSS district offices act as the case managers, doing the assessment, authorization, and monitoring of care. (There is no nursing home preadmission screening.) The department delegates all case management work "in-house" to its local offices. Michigan's arrangement lacks a formal "check and balance" on the client assessment process, in that the same worker who assesses client need also "hires" the caregiver. Theoretically (and legally) the client

actually employs the caregiver.

In contrast, the Illinois program separates assessment and delivery between two distinct agencies, the CCU and the provider. Selection of the contractor is a matter of which local agencies have the contracts and have space available. The client and CCU worker are constrained in their choice of provider by the contracting system.

Determining Need

The local CCU in Illinois determines the number of hours of care that are needed by a client, i.e. care to supplement the amount already being provided by family or friends. Only care in addition to that being provided by th informal system can be authorized. This determination then authorizes the local contract agency (a not-for-profit or proprietary) to begin service delivery. Contract agencies hire employees (usually full time) to provide the direct service. In contrast, the Michigan DSS caseworker determines the total number of hours of care required, and negotiates a three way contract with the client and the service provider to actually provide care. Care already provided by friends or relatives (except spouses or parents of minors who are financially responsible) is compensated for, as well is additional service needed.

Hiring Relatives and Friends

In Illinois there is no policy prohibiting the hiring of relatives. A survey of 76 provider agencies in Illinois conducted in June 1985 found that 39% of Illinois contract agencies would permit hiring of relatives under certain circumstances, including situations where regular employees are unavailable, an agency employee would have difficulty meeting particular client needs, or if staff capacity is

overextended.[12] The state neither encourages or discourages the hiring of relatives, nor would it gain economically by either policy. The state reimbursement rate, which includes overhead/supervision costs, is the same whether the provider agency hires its own staff or a relative or friend. The employment of a relative provider is sometimes recommended by a CCU.

The Michigan DSS, on the other hand, prefers to hire relatives and friends, and does so directly. About 90% of worker wages are made to informal providers rather than to agencies, and about half of these are relatives of the client. Caseworkers go through agencies "only in the more difficult cases" or when no informal caregivers can be found. Agencies command a higher rate of payment, typically $7 per hour versus approximately $3.65 per hour paid to informal providers. The state can serve more clients or maximizes the amount of time purchased per client by hiring mostly informal care providers, partly because they are untrained and only minimally supervised.

To summarize, in Michigan the state exercises program authority, it sets reimbursement on the basis of total client needs without discounting for care already provided, and it systematically encourages paying informal caregivers. In Illinois the state contracts program authority to private agencies, it discounts for care already provided, and it systematically encourages professional care by relying on formal agencies.

Program Background, Financing, and Flow of Funds

Centralization of Program Finances

The Illinois Department on Aging (DOA) is a unified service system providing an entitlement to all persons over age 60 in need of home care. Those with incomes above poverty and not Medicaid eligible may also use the CCP, paying according to a sliding fee scale.

Michigan's is a means-tested welfare system. Only poor persons are served and the local DSS offices are the main source of available state assistance. Provisions for non-categorical clients come through the limited state aging agency or private sources. They are underdeveloped when compared to those in Illinois, as can be seen in the expenditures (in thousands) and proportions from different funding sources compared on Table II. Michigan's is a bifurcated system of

TABLE II ABOUT HERE

services for the elderly with priority on categorical services.

Categorical Financing and Its History

By FY85 Michigan used Medicaid financing for fully 75% of the Adult Home Help program, and 72 % of all state-provided home care. State general funds support 66% of total home care funding between both DSS and the state aging agency. In Illinois Medicaid finances only 29% of the total CCP program, and 85% of the program is supported with state funds. Michigan's reliance upon categorical Medicaid funding has apparently stimulated little expansion of services for income eligibles, whereas the greatly expanded Illinois CCP is available for all elderly persons, including higher income clients through fees. The explanation for these priorities lies in the reasons Medicaid was included in each program.

Michigan altered its Medicaid program in 1981 when severe economic pressure threatened the very survival of the Adult Home Help Program. Previously funded with Title XX, the Home Help program already had 19,800 categorical clients. By adding personal care as a benefit to its Medicaid plan, most of the Home Help program clients became eligible for Medicaid reimbursement, thus sustaining the program.[13]

Illinois, on the other hand, added Medicaid funding in 1983, when the state was experiencing growing demand for nursing home beds because of closure of three state institutions. The courts declared the IDOA CCP to be an "entitlement" and standardized services had to be designed for statewide delivery, so the IDOA acquired a Medicaid 2176 waiver. Thus, in Illinois federal Medicaid match facilitated expansion of services while in Michigan it largely supplanted state money.[14]

Program Utilization and Unit Costs.

Program utilization and annual expenditures in Illinois grew very quickly after the Community Care Program began in 1979, but especially after the Medicaid waiver was obtained in 1983, as can be seen on Table III. Utilization in Michigan, grew much more gradually since Home Help began in the early 1970's and did not increase with the infusion of Medicaid funding. The Illinois rapid growth reflects a pattern typical of states which received Medicaid waivers in the early 1980's[16] and purchase care from formal agencies.

INSERT TABLE III ABOUT HERE

While average monthly costs appear to be similar in the two states, in FY1986 the maximum allowable payment in Michigan was $333 per month while in Illinois it was $980 per month. The Michigan maximum payment was kept just low enough to avoid including workers'

compensation costs in the payments. The average payment, however, was about $170. Michigan also has an exception policy for some higher cost clients. The Illinois maximum is the cost limit set relative to the cost of institutional care as required by the Home and Community Based waiver and the program's nursing home screening function. While average clients cost about the same in both states, the bases for this cost in entirely different.

To summarize, Michigan retained a categorical program tied to the welfare system to sustain clients, their families, and the state through difficult economic times by maximizing federal aid, through a direct limit on per client costs. Illinois created an entitlement to service for all elderly persons through a more discretionary limit on per client costs and indirect controls on agency costs which supports agency interests at much greater state cost.

Client Impacts

Determination of Eligibility and Functional Assessment

In both states eligibility is determined by meeting guidelines for 1) income, 2) assets, 3) a physician's certification of medical need, and 4) a functional assessment performed by a DSS worker in Michigan and a CCU contract agency worker in Illinois.

Both states' eligibility and functional assessment forms weigh the same factors, but the eligibility criteria start from different basic assumptions. The Michigan DSS worker asks the client "what services do you need?" identifying appropriate individuals in the client's "Eco-system" who can help with each need.[13] Some of these persons are already helping, and contracting with them is seen simply as a way to

assure their continued involvement. Whether or not services are currently being provided ("for free") is of little consequence to DSS, and the availability of informal providers is considered to be an asset. Notes one DSS worker:

> Some of the best chore providers are friends who the client found. Many already are helping anyway. This just formalizes it. Our first approach is to have the client identify who could be a provider. We feel it works best when the client already knows the worker. Some take the money reluctantly, but they take it just the same.[15]

The Home Help payment (or stipend) is seen as a way "to keep helpers in the picture," and to help caregivers purchase what might be necessary to facilitate appropriate care. The DSS worker draws up a client service plan, which is reviewed by a nurse in the central office, then negotiates a contract with the client and the provider (both client and provider names appear on the monthly reimbursement checks) and monitors the time sheets submitted monthly by the provider.

In Illinois the CCU, which is reimbursed by the Department of Aging on a per unit basis, assesses what the client needs that is not currently being provided. Assessment is directed at "filling gaps" and identifying only currently unmet needs. The CCU authorizes the contract agency to provide a certain amount of care by deploying its employee, and then monitors care periodically .

Basically, then, the Illinois program "discounts" for work already being provided and assumes that it will continue without compensation. The Michigan program sees this caregiving work as sufficiently vital to the client to compensate for it. The Michigan program stimulates provision of uncompensated time, simply because a closer bond exists between informal caregivers and their clients.

Caregiver Consistency and Turnover, Client Preferences, and Client Efficacy.

A 1985 evaluation of the Michigan program provides evidence that informal caregivers provide clients more regular, consistent and reliable care.[16] In initiating competitive bidding among contractors, Illinois stimulated a significant turnover in agency contracts in fiscal years 1984 and 1985, affecting a substantial proportion of the program's clients. Stability of the caregiving relation was more assured by the program contracting with informal caregivers.

Consistent informal care can have shortcomings: it may promote dependence, not always be in the best interest of the client (or the caregiver who is at risk of burnout), or preclude use of better trained and consistently productive workers. Yet, formal care providers, hired to do specific tasks, cannot be permanently depended upon.

Offering the client a choice of provider respects his or her preferences in general, and may lead to more individualized attention. The continuity of an agreeable provider further allows the client to assert preferences in little choices of daily living. Allergies to household products, food tastes, and preferences in over-the-counter medications, daily routines, or favorite TV shows might constitute basic reasons an older person wants to remain at home. These preferences may in fact reinforce positive behavior and therefore promote activities which decrease deperession and social isolation.[17] Knowing these "reinforcers," regular providers can be less intrusive and more respectful.

One Michigan DSS worker noted

> There is continuity of care in getting the same person every day, but you get no such guarantee with a home health agency. With the

> same person the client gets security, the same things and the same routines. Some clients get less paranoid.

In allowing the client and his or her family to select the caregiver, the client's preference is paramount, but when a contract agency chooses the caregiver, bureaucratic imperatives delimit the choice of client helpers. Agencies are constrained by formal procedures and legal sanctions, for example, they "...must not discriminate in any way. If the clients don't like it, they go without service."[18] Home care aides are often assigned at random without regard to client characteristics. Client preferences are difficult to honor.

Finally, Michigan workers feel that contracts with informal care providers enhance client feelings of efficacy, dignity and reciprocity with their caregivers. The check written to clients eligible for welfare and highly dependent upon others gives such persons some, albeit limited, control over the care they receive. This control helps preserve personal dignity, especially when the care is provided by a relative or friend. As another DSS worker observed:

> The client is happy that the helper is getting something for their effort, some benefit. This allows them a more secure feeling. Also this assures them that care will continue. The worker is answerable to the state, to someone else besides the client, so they are expected now to do certain things.
>
> The client also feels like less of a burden, like they are "paying their own way," and are less of an imposition on the helper.

The Illinois program requires the client to accept whatever is given from whomever gives it. The client is relieved of being the "employer" of the provider, but typically is still reliant to some extent on unpaid informal caregivers, anyway.

Professionalism, Quality Assurance, and Service Linkages

What the Michigan program offers in consistency and client satisfaction, the Illinois program compensates for in professionalism and appropriateness. In Illinois the professonal medical orientation of most provider agencies assure that medical needs are monitored for a larger number of clients. Neither program is "supposed" to provide medically oriented care, though both do provide medication monitoring, dressing changes, exercise, and other medically related care to some extent. Contract agencies have direct access to medical backup.

Neither state provides much monitoring of quality of care. In Illinois there are annual client reassessments by the CCU and, of course, workers are supervised by their agency. The Michigan DSS caseworker reviews the case in 90 days after eligibility and then every 6 months. She only provides ongoing supervision if a problem arises. The division of labor in the Illinois arrangement theoretically provides more quality assurance.

As the medical needs of the elderly grow in the future, and increasingly skilled health care interventions are required, the need for low skill caregivers will not decrease, but state monitoring staffs are not likely to ever increase sufficiently to guarantee quality care. The director of the Michigan program has noted that in seventeen years: "We've never had a major disaster or a scandal in all this time."[19] The good will and diligence of a family support network will probably remain the best oversight a client can rely upon in the future.

Being separated from the "aging network" of the state aging agency, the Michigan program limits client access to knowledge of other services. On this dimension the Illinois program seems stronger,

although oversight by the case managers as well as networking are significantly limited by large caseloads and narrowness of functions.

Respite for Informal Caregivers.

Neither state funds respite care of informal caregivers directly, although both home care services facilitate it. While Michigan allows paid informal caregivers to spend the money received as they choose, the actual number of hours provided are only loosely accounted for, and caregivers are free to "subcontract" care in order to get time off. This flexibility is more difficult to arrange in Illinois, since the agency worker is not to substitute for the care informal caregivers already provide. In providing direct care for the client, however, the CCP does allow the informal caregiver time off also.

To summarize, the differences in client impacts include the implications of the state's practices of using professional vs. non-professional caregivers, "discounting" of informal caregiver time and effort, consistency of care, tendency to support and honor the client's preferences, support of client control, extent of external monitoring, and extent of caregiver respite.

Discussion and Implications

This examination has shown that a state's choice to reimburse formal as opposed to informal caregivers has powerful implications for client care and that it creates further incentives for administering agencies. While both agencies and informal caregivers have proven to be effective paid providers, neither care delivery strategy is unequivically "better" for states or clients. Each has its strengths.

In the policy development stage in both states there was heated

debate about the "morality" of paying family members to do what is perceived by some as "already their duty." Interestingly, this question received little attention after a choice was made. In Michigan one DSS social worker noted:

> Back in 1969 there was a lot of controversy about paying parents or relatives. Now we just take it for granted. There is no question about it [now], that's the rule.[20]

Indeed, questions of "who" to reimburse for what are heavily value-laden, not simple issues of efficiency or even effectiveness. Policy decisions made on the basis of political pressures or assumptions about the services of a network of agencies are rationalized as a response to client needs. Yet, what is truly best for elderly persons and their support systems is not easily discovered in systems that are overly proscribed. Client needs can be easily obscured by suggestions of "immorality" in paying families. And once precedents are set, state policies gain a directional momentum.

As increasing numbers of families acquire an interest in home care, making it a highly charged issue, community-based and post-hospital services grow and home care agencies are emerging as a significant political force in the state houses. The formal home care "industry" that has developed rapidly in Illinois now has a vital stake in future discussions of family involvement. If poor families are to remain an acknowledged part of client support systems, rather than simply a lower cost alternative to agencies, they will probably need a lobbying capacity too. The formal care system has developed in lieu of a system that could have reimbursed informal caregivers--an alternative that Michigan's experience indicates is still a reasonable alternative

for serving a significant portion of poor elderly clients.

Medically oriented provider organizations typically strive to maintain their discretion, generating revenue, operating efficiently, and (especially in highly competitive markets) satisfying their consumers. While hiring informal caregivers might enhance patient satisfaction, this alternative can be accepted by an industry only if its survival is assured first. The home health industry in Illinois now lobbies toward that end.

No such organized lobby has developed in Michigan where the state Home Help beneficiaries are low-income citizens receiving small grants (and home health agencies serve mainly non-Medicaid clients). These individuals are not organized, and could not be organized easily. Low-income elderly frail and disabled clients, and their caregivers (children and friends) have little basis for even knowing each other, much less organizing. The interests of the Home Help family caregivers are disparate and not strong ones for lobbying. Advocacy groups, such as the Alzheimers and Related Disorders Association, nursing home reform groups, and professional societies have only recently begun to focus public attention upon informal care.

Professional bias, organizational imperatives, and political pressures all too often shape policy makers perceptions of family and informal care, encouraging reimbursement incentives that either exploit informal caregivers or under value them. Professionals and government employees (who are hopefully insulated from interest group bias) should be sensitive to appropriate informal caregiving, dispassionately weigh the strengths and weaknesses of reimbursing informal caregivers, and advocate for consideration of this policy option.

For example, in Illinois where state workers have little discretion at the direct service level, policy and organizational changes are still possible. The state could adopt policy guidelines for contract agencies about when to "hire" informal caregivers, or the CCU could arrange care directly with informal caregivers in concert with client choice, bypassing the contract agency. Sending in an agency "stranger" could, indeed, be made the option of last resort, rather than the first. In Michigan more options, orientation, and training opportunities could be offered to paid informal charegivers. DSS could encourage development of special purpose agencies, cooperatives, and respite care. The alternatives suggested by each of these states are worth consideration by the other, in order to expand the choices open to clients and those who care for them.

The development of the Michigan and Illinois programs show how home care program structure and financing can incrementally become two distinct models of service delivery, one client-centered and one agency-centered, with very different implications for clients,. While this analysis could not, of course, account for variation in practices throughout each state, available evidence has highlighted the implicit values and impacts of client policies.

Under American laissez-faire federalism, values and precedents which are quickly reified into a program in one state are sometimes thoroughly overlooked by a neighboring state. [21] Since policy makers can be pursuaded by good experience as well as by political pressure, we believe more attention to client and caregiver satisfaction would serve to make payment to informal caregivers a more widely acknowledged policy option.

Glossary of Abbreviations

DOA. Illinois Department of Aging
CCP. Illinois Community Care Program
CCU. Case Coordination Unit. Agencies that determine eligibility for the Illinois Community Care Program.
DSS Michigan Department of Social Services
AHH. Michigan Adult Home Help Program
2176. The Section of the 1981 Omnibus Budget Reconcilliation Act which authorized Medicaid waivers for Home and Community Based Care. Illinois has such a waiver to provide services to the aged and Michigan does not.

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13. To avoid the Medicaid prohibition on provision of personal care by relatives, the state narrowed its definition of "family" to include only relatives who were financially responsible, thus allowing most relatives caring for the elderly (about half of all Home Help providers) to continue to be eligible for Home Help payments.

14. Michigan's choice to utilize a regular Medicaid service (personal care) rather than a waiver may have precluded the close scrutiny by the federal Health Care Finance Administration that Illinois and other waiver states have experienced. Michigan complies with the Medicaid requirement for nurse supervision of personal care by having a nurse in the central state office do a "paper review." This can be variously perceived as an administrative efficiency (DSS avoids significant state quality assurance costs) or a weakness (lack of federal oversight permits poor care).

15. Interview with a Michigan DSS worker, November 1986.

16. "Client Data Profile," Independent Living Services,Michigan DSS. April 1985.and Nye, Jim. Adult Home Help: Profile Update and Analysis., Michigan DSS, January 1982. These two evaluations showed that the mean age for both clients and caregivers increased by four years in four years. (This may also be evidence that few new (younger) clients are being admitted to the program.) Increasingly the caregivers tend to co-reside with the clients.

17. Pinkston and Linsk, 1984; Zaret, 1980.

18. Interview with staff at a Michigan home care agency, October 1986.

19. Linsk, et al. 1987.

20. Interview with director of the Michigan Adult Home Help program, June 1986.

21. Interview with a Michigan DSS Adult Services Worker.

22. While the evidence presented in this study may seem subjective, it has yielded very salient questions about client benefits in the two states. In qualitative research such exploration has been called "perspectival." For a description of such generative methods and their value, see Lincoln, Y. The Paradigm Shift in Organizational Theory. (Beverly Hills, CA: Sage, 1986.)

TABLE I.

Program and Policy Analysis Model

Prog	Michigan Adult Home Help --Client Based Care	Illinois Community Care --Agency Based Care
Historical	Longer term commitment to home and personal care. Began 1970. Slow but steady growth	Program emerged as a governor's initiative 1980. Spurt growth after 1983.
Basic Program /Policy Model	More entitlement oriented	More residual--need based with co-payments based on income/assets;restrictive
	Categorical up to 133% of poverty. No sliding scale.	Sliding fee scale.
Objectives	Maintain recipient in own home and support natural support system	Maintain recipient in own home to keep elderly people out of nursing homes
	No NH preadm screening	NH preadm screening to divert admissions
Target of Benefits	Strengthening the "Ecosystem" as a whole	The elderly client only, but also contract agencies
Provider agencies	90% Informal caregivers: family or friends 10% served by formal ags.	Home care contract
Program Size in FY86	17,280 elderly Home Help clients (72% of total). About half of providers are relatives	22,000 CCP clients. Only a small number of providers are relatives (most contract agencies do not hire relatives);
Financing	Medicaid Personal Care, State funds, & Social Service Block grants (formerly)	State funds, Medicaid (2176 waiver) and and Social Service Block grants (formerly)

Table II.

Home Care Program Costs in FY1985, and Revenue Sources

	Michigan		Illinois
	*DSS Home Help	Aging Agency	Dept of Aging Community Care Progm
State GF	15,600.0		36,000.0
Medicaid	47,100.0		15,000.0
fed	23,550.0		7,500.0
state	23,550.0		7,500.0
Total	62,700.0	2,500.0	51,000.**

*Counts clients of all ages. Actually 72% of clients are aged.
Source: Michigan Department of Social services.

**Source: Illinois Department of Aging.

Table III.

Program Annual Cost and Utilization (in $ thousands)

	Michigan Home Help Only	% chg	Illinois	% chg
FY 84 # served/mo	14,910		14,240	
$ annual	$40.3 million		$36.6 million	
Avg monthly cost	$225		$	
FY85 # served /mo	16,344	9.6%	19,524	37.1%
$ annual	$45.1 million		$51 million	
Avg monthly cost	$230		$213.	
FY86 # served /mo	16,792	2.7%	22,085	13.1%
$ annual	$16.1 million		$62 million	
Avg monthly cost	$270.		$221.	
Maximum allowable per mth	$333		$980	
FY87 # served/mo	17,220	2.5%	23,871*	8.1%
$ annual	$51.2 million		$79 million	
Avg monthly cost	$248		$243.	

*These figures are estimates.

Sources:

Illinois Department of Aging.

Michigan Department of Social Services, Adult Home Help Program. AHH Program utilization and expenditures are adjusted here to reflect only the utilization made by the elderly: 70% of all utilization in FY87, 71% in FY86, 72% in FY85; and 71% in FY84.